

Medicare Part B Reopenings Date of Service Adjustment Request Form

DOS 568

State Kentucky Ohio Date _____
Contact _____ Phone Number _____

Provider Information

Name _____ Last 5 digits of Tax ID Number _____
Billing PTAN Number _____ Billing NPI Number _____

Beneficiary Information

Name _____
Medicare Number _____

Service Date _____ HCPCS _____ ICN (one claim per form) _____

Adjustment Details

Line	From DOS New Value	To DOS New Value
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
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Send to
J15 - Part B Correspondence
CGS
PO Box 20018
Nashville, TN 37202

